SERFF Tracking Number:	*CAKN-126707906*	*State:*	*Arkansas*
Filing Company:	*Catholic Knights*	*State Tracking Number:*	*46131*
Company Tracking Number:	*19-710*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.111 Single Premium - Single Life*
Product Name:	*SPWL*		
Project Name/Number:	*CNO-19/19-710*		

Filing at a Glance

Company: Catholic Knights

Product Name: SPWL	SERFF Tr Num: CAKN-126707906	State: Arkansas
TOI: L07I Individual Life - Whole	SERFF Status: Closed-Approved-Closed	State Tr Num: 46131
Sub-TOI: L07I.111 Single Premium - Single Life	Co Tr Num: 19-710	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Author: Donna Peterson	Disposition Date: 07/08/2010
	Date Submitted: 07/06/2010	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: CNO-19	Status of Filing in Domicile: Pending
Project Number: 19-710	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments: This product was filed with the Interstate Compact. Wisconsin, our state of domicile, is part of the compact.
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 07/08/2010	Explanation for Other Group Market Type:
	State Status Changed: 07/08/2010
Deemer Date:	Created By: Donna Peterson
Submitted By: Donna Peterson	Corresponding Filing Tracking Number:

Filing Description:

We are a Fraternal Insurance Society filing a Whole Life Insurance product form number 2010 SPWL. This is a Single Life, single premium,fixed premium product. It will be used with application 2010 LF APP approved by AR on June 16, 2010, SERFF filing number: FRCS-126669812. It will be illustrated.

The wording of this contract is similar to the Whole Life product filed with AR on July 2, 2010 SERFF no. CAKN-126705325. The differences relate to a single premium product.

SERFF Tracking Number:	*CAKN-126707906*	*State:*	*Arkansas*
Filing Company:	*Catholic Knights*	*State Tracking Number:*	*46131*
Company Tracking Number:	*19-710*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.111 Single Premium - Single Life*
Product Name:	*SPWL*		
Project Name/Number:	*CNO-19/19-710*		

To the best of our knowledge this filing is complete and intended to comply with the insurance laws of your jurisdiction

Company and Contact

Filing Contact Information

Donna Peterson,
1100 W Wells Street
Milwaukee, WI 53233

donnap@cfli.org
414-278-6509 [Phone]

Filing Company Information

Catholic Knights
1100 West Wells Street
Milwaukee, WI 53233
(414) 273-6266 ext. 6468[Phone]

CoCode: 56030
Group Code:
Group Name:
FEIN Number: 39-0201015

State of Domicile: Wisconsin
Company Type: Fraternal
State ID Number: 2796

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Catholic Knights	$50.00	07/06/2010	37756985

SERFF Tracking Number:	*CAKN-126707906*	*State:*	*Arkansas*
Filing Company:	*Catholic Knights*	*State Tracking Number:*	*46131*
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Project Name/Number:	*CNO-19/19-710*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	07/08/2010	07/08/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Linda Bird	07/07/2010	07/07/2010	Donna Peterson	07/07/2010	07/07/2010

SERFF Tracking Number:	*CAKN-126707906*	*State:*	*Arkansas*
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Product Name:	*SPWL*		
Project Name/Number:	*CNO-19/19-710*		

Disposition

Disposition Date: 07/08/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*CAKN-126707906*	*State:*	*Arkansas*
Filing Company:	*Catholic Knights*	*State Tracking Number:*	*46131*
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Product Name:	*SPWL*		
Project Name/Number:	*CNO-19/19-710*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Illustration Certification		Yes
Supporting Document	Regulation 19 Certification		Yes
Form	Single Premium Whole Life		Yes

SERFF Tracking Number:	*CAKN-126707906*	*State:*	*Arkansas*
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Product Name:	*SPWL*		
Project Name/Number:	*CNO-19/19-710*		

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/07/2010
Submitted Date	07/07/2010
Respond By Date	08/09/2010

Dear Donna Peterson,

This will acknowledge receipt of the captioned filing.

Objection 1
No Objections
Comment: Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Please feel free to contact me if you have questions.
Sincerely,
Linda Bird

SERFF Tracking Number:	*CAKN-126707906*	*State:*	*Arkansas*
Filing Company:	*Catholic Knights*	*State Tracking Number:*	*46131*
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Product Name:	*SPWL*		
Project Name/Number:	*CNO-19/19-710*		

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	07/07/2010
Submitted Date	07/07/2010

Dear Linda Bird,

Comments:

Response 1

Comments: Regulation 19 Certification added to Supplementary Documentation tab.

Related Objection 1

Comment:
Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provisions of this rule as well as all applicable requirements of this Department.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Regulation 19 Certification
Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Thank you for your help with this filing.

Sincerely,
Donna Peterson

SERFF Tracking Number:	*CAKN-126707906*	*State:*	*Arkansas*
Filing Company:	*Catholic Knights*	*State Tracking Number:*	*46131*
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Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	2010 SPWL	Policy/Cont ract/Fratern al Certificate	Single Premium Whole Life	Initial		52.500	SPWL fnl ck vrsn 7-5 (ar).pdf

[CATHOLIC KNIGHTS]

[CATHOLIC KNIGHTS]
1100 West Wells Street
Milwaukee Wisconsin 53233
800-927-2547
[www.catholicknights.org]

Insured: [John Doe]
Certificate Number: [123456]

SINGLE PREMIUM WHOLE LIFE INSURANCE
Insurance Payable at Death of Insured
Participating

READ YOUR CONTRACT CAREFULLY This is a legally binding insurance contract between you and Catholic Knights. The contract is issued based on the signed application and receipt of the full payment of the initial premium.

Catholic Knights agrees to pay the benefits provided in this contract subject to its terms and conditions upon receipt of due proof of the insured's death. We will pay the insurance proceeds (see Section 3.1) to the beneficiary according to the provisions of this certificate.

RIGHT TO CANCEL – The owner may cancel this contract for any reason before midnight on the twentieth (20th) day after the owner received the certificate. If the contract is a replacement contract the owner may cancel this contract for any reasons before midnight on the thirtieth (30th) day after receipt of the certificate.

This is done by delivering or mailing a written notice and the certificate to Catholic Knights, 1100 West Wells Street, Milwaukee, Wisconsin 53233, to our authorized agent through whom you purchased the insurance, or to any Catholic Knights authorized agent. If mail is used, it is effective on the date postmarked with a correct address and sufficient postage. Catholic Knights will return all payments for this insurance within ten (10) days after it receives the notice and the certificate. This contract will then be void from the beginning.

Signed at our Home Office in Milwaukee, Wisconsin, on the certificate date.

[William R. O'Toole] [Allan G. Joyce]

President Secretary

TABLE OF CONTENTS

SECTION 1 CONTRACT SPECIFICATIONS

INSURED: [John D. Doe]
ISSUE AGE: [35] **SEX:** [male]

FACE AMOUNT OF INSURANCE: [$100,000]
CERTIFICATE NUMBER: [1234567]

CERTIFICATE DATE: [9/1/2010]

PREMIUM CLASS: [NON-TOBACCO]
[RISK CLASS: TABLE 4]

OWNER: [John D. Doe]

DIVIDEND OPTION [Left on Deposit]

CONTRACT LOAN INTEREST [7%]

EFFECTIVE ANNUAL INTEREST RATE FOR REINSTATEMENT: 6%

SCHEDULE OF BENEFITS AND PREMIUMS

DESCRIPTION	**BENEFIT AMOUNT**	**SINGLE PREMIUM**	**EXPIRES ON CONTRACT ANNIVERSARY DATE**
Whole Life	[$100,000]	[$22,886.00]	[2096]
Policy Fee		$75.00	
Total Single Premium		[$22,961.00]	

DIVIDENDS are not guaranteed. We do not expect that any dividend will be paid for this contract until at least two years (2) from the certificate date.

BENEFICIARY As stated in the application unless subsequently changed as provided in this contract.

The effective date and issue age of each benefit is the certificate date and issue age provided in the certificate, unless otherwise specified.

The telephone number of the [AR Department of Insurance is 501-371-2600]

SECTION 2. DEFINITIONS

YOU and **YOUR** refer to the owner of this insurance contract. The owner is as shown in Section 1, unless later changed as provided in this contract. The owner may be someone other than the insured.

WE, **US** and **OUR** means Catholic Knights, a fraternal benefit society.

AGE means the age of the insured on his or her last birthday.

The **BENEFICIARY** is the person who has a right to receive the death benefit proceeds.

The **CERTIFICATE DATE** is the date this contract goes into effect. It is shown in Section I.

The **CONTRACT** is this certificate, together with the application and any riders. Our Amended and Restated Articles of Incorporation and Bylaws also are part of the contract.

CONTRACT YEARS, ANNIVERSARIES and **MONTHS** are measured from the certificate date shown in Section 1. For example, if the certificate date is September 1, 2010, the first year ends August 31, 2011. Contract anniversary means the same month and day as the contract date for each year the contract remains in force. The first contract year begins on the contract date and ends at 11:59 p.m. on the day prior to the first contract anniversary. Subsequent contract years begin on a contract anniversary and end at 11:59 p.m. on the day prior to the next contract anniversary.

IN FORCE means the insured's life remains insured under the terms of this contract. This contract is in effect.

The **INSURED** is the person named in Section 1 at whose death the insurance proceeds will be payable.

A **RIDER** is an attachment to the contract. It provides additional benefits.

TERMINATE means the insured's life is no longer insured under any of the terms of this contract. This contract is no longer in effect.

WRITTEN A written request or statement signed by you and received in good order by us at our Home Office.

To make this certificate clear and easy to read, we have left out many cross references and conditional statements. Therefore, the provisions of the certificate must be read as a whole.

SECTION 3 GENERAL PROVISIONS

3.1 Insurance Proceeds

When the insured dies, an amount of money, called the insurance proceeds, is payable to the beneficiary. The insurance proceeds are the total of:

- The Face Amount of Insurance
  PLUS
- Any insurance on the insured's life which may be provided by riders to this contract
- Any insurance bought with dividends
- Any dividends left with us to earn interest
  MINUS
- Any indebtedness

3.2 Payment of Interest on the Insurance Proceeds

a. The insurance proceeds will be paid to the beneficiary within one month after we receive due proof of the insured's death and the claimant's right to payment. We will pay the insurance proceeds in one lump sum unless one or more of the optional payment plans described in Section 10 are selected.

b. We will pay interest on the proceeds from the date of death to the date of settlement at the rate paid on the date of death for funds left on deposit with us.

c. Interest shall accrue at the effective annual rate determined in Item (b) above, plus additional interest at a rate of 10% annually beginning with the date that is 31 calendar days from the latest of Items (i), (ii) and (iii) to the date the claim is paid, where it is:

(i) The date that due proof of death is received by the society;

(ii) The date the society receives sufficient information to determine it liability, the extent of the liability, and the appropriate payee legally entitled to the proceeds; and

(iii) The date that legal impediments to payment of proceeds that depend on the action of parties other than the society are resolved and sufficient evidence of the same is provided to society. Legal impediments to payment included, but are not limited to (a) the establishment of guardianships and conservatorships; (b) the appointment and qualification of trustees, executors and administrators; and (c) the submission of information required to satisfy a state and federal reporting requirements.

3.3 The Contract

This contract is issued in consideration of:

a. your application;
b. the single premium; and
c. the contract and rider provisions.

The entire contract consists of:

a. this certificate;
b. any additional benefits provided by rider;
c. the attached application;
d. any required medical examination or declaration of insurability; and
e. our Amended and Restated Articles of Incorporation and Bylaws, as amended from time to time.

No change in this contract is valid unless it has been approved under the authority of the Interstate Insurance Product Regulation Commission and by the President or Secretary of [Catholic Knights]. No agent has the authority to change or modify this contract or waive any of its provisions. No change in our Articles of Incorporation or Bylaws as amended made after the contract date shall reduce or change the benefits promised in this contract. You may continue this contract in force even if membership in the [Catholic Knights] is terminated except within the contestable period for material misrepresentation in the application. No provision in the Articles or Bylaws provides for the termination of coverage under this contract.

All statements made by the applicant for issuance, reinstatement or renewal of this contract shall, in the absence of fraud, be deemed representations and not warranties. We will not use any statement, unless made in the application, to void this contract or to deny a claim.

3.4 Incontestability
This Contract will not be contested by us after it has been in force during the lifetime of the Insured for two (2) years from the Certificate Date except for fraud in the procurement of this Contract when permitted by applicable law in the state where this contract is delivered or issued for delivery.

3.5 Suicide
If the insured dies by suicide, whether sane or insane within two years of the contract date, the only amount payable to the beneficiary will be the premium paid without interest less any indebtedness.

3.6 Misstatement of Age or Sex
If the age or sex of any insured has been misstated, the amount payable will be the amount which the premium paid would have purchased at the correct age and sex.

3.7 Maintenance of Legal Reserves
The reserves held on your contract are computed according to the standards prescribed by law. If, for any reason at any time, we do not have sufficient assets to cover the reserves, the Board of Directors may require that the amount of such deficiency shall be equitably apportioned to all outstanding policies. The amount thus apportioned to your contract shall either:

a. be paid in cash by you; or
b. be an indebtedness against your contract at a rate of interest of eight percent (8%) per annum; or
c. with owner consent be an equivalent reduction in benefits.

3.8 Termination
The contract will terminate:

a. when we receive written notice to terminate; or
b. when the insured dies; or
c. on the expiry date shown in Section 1; or
d. if indebtedness exceeds the cash value as described in section 8.4.

In the event of termination or expiry of this contract we will pay you any outstanding dividends. *(Compact P7 page 15)*

3.10 Forms and Procedures
We may require the owner to follow our procedures and to use our forms to take any action, such as changing a beneficiary or requesting a payment. We may require the owner to submit this certificate for endorsement to show any change. The owner may obtain any information and forms from an authorized agent or the home office.

SECTION 4. OWNERSHIP

4.1 The Owner
The owner is named on page 3. The owner may exercise all contractual rights during the lifetime of the insured, without the consent of any beneficiary unless the beneficiary has been made irrevocable. These rights may be exercised only during the lifetime of the insured.

4.2 Transfer of Ownership
You may transfer the ownership of this contract during the lifetime of the insured. Written evidence of transfer satisfactory to us must be received at our home office. The transfer will then be effective as of the date it was signed subject to any payments made or actions taken by the society prior to receipt of the transfer.

4.3 Successor Owner
The contract owner may designate a successor owner to assume the responsibilities and duties of the contract owner in the event of the death or disability of the contract owner. The successor owner may be an individual, at least 18 years of age, or a corporation, partnership, trust or other entity. The successor owner has no rights in regard to the contract and cannot direct any changes, conversion, transfers or cancellations, except in the event of the death of the contract owner. The contract owner may change the designation of the successor owner at any time.

4.4 Collateral Assignment
You may assign this Contract as collateral security. We assume no responsibility for the validity or effect of any collateral assignment of this Contract. We will not be responsible to an assignee for any payment or other action taken by us before receipt of the assignment in writing at our Home Office.

The interest of any beneficiary will be subject to any collateral assignment made either before or after the beneficiary designation. The rights of an assignee may not come before the rights of an irrevocable beneficiary that is designated prior to the assignment.

You must give us notice of an assignment. An assignment, unless otherwise specified by the owner, will be effective on the date signed, subject to any payments made or actions taken by us prior to receipt of such notice.

A collateral assignee is not an owner. A collateral assignment is not a transfer of ownership. Ownership can be transferred only by complying with Section 4.2.

SECTION 5. PREMIUMS AND REINSTATEMENT

5.1 Premium Amount
The single premium is due and must be paid as of the Certificate Date. If you want a receipt for the premium payment, we will provide one upon request.

SECTION 6. DIVIDENDS

6.1 Annual Dividends
Each year, we determine an amount to be paid to you. The share, if any, for this contract, will be paid as a dividend at the end of the contract year. We do not expect that any dividend will be paid for this contract until at least two years (2) from the certificate date.

6.2 Use of Dividends
You may choose in writing to receive any dividend which may be declared in one of these ways:

a. CASH – Payment back to you by check.
b. PAID UP ADDITIONS – To buy more insurance on the insured's life.
c. DEPOSIT ACCOUNT – To be left with us to earn interest at the rate we set from time to time. The rate will not be less than one and one-half percent (1-1/2%)

Your choice may be made on the application for your contract, or in writing at a later date. If no choice is made, Option c. will be applied.

6.3 Expiry of Contract
In the event of expiry of this contract, we will pay you any outstanding dividends, unless you have previously selected another dividend option listed above.

SECTION 7 CASH VALUES

7.1 Guaranteed Values
The contract has a guaranteed value. This is the cash value. Cash values are shown in the Table of Guaranteed Values.

You may surrender the contract for the cash surrender value at any time, and if you surrender the contract within thirty (30) days of a contract anniversary date, the Net Cash Value will not be less than the Net Cash Value as of that contract anniversary date.

We may defer the payment of the Net Cash Value for a period not to exceed six months after the request for surrender of the contract, and we will comply with any applicable law concerning the timing of our payment or interest on it.

If the owner surrenders the policy, such surrender may result in a substantial penalty because the cash value of the policy may be less than the premium paid.

7.2 Basis of Values
Guaranteed values, present values, and net single premiums, in this contract are based on the Commissioner's 2001 Standard Ordinary Male and Female Ultimate Mortality Tables. Interest is at five percent (5%) per year.

All computations consider that the contract is issued on the basis of the Insured's sex and age at last birthday. They are also based on the assumption that death benefits are payable immediately upon death.

The commissioner's Reserve Valuation Method is used in the calculation of reserves.

We have filed a detailed statement of the method of computation with the insurance supervisory official of the state in which this contract is delivered. The cash surrender values available under this contract are equal to or greater than those required by the law of any state in which this contract is delivered.

7.3 Table of Guaranteed Values
The guaranteed values applicable for the contract are shown in the Table of Guaranteed Values for the issue age, sex and premium class for the face amount shown on page 3.

Values shown apply at the end of the contract year. The values of any other time will be determined giving allowance for the part of the year since the last contract anniversary. Values at the end of the contract years not shown will be furnished upon request. Cash values and paid-up Nonforfeiture benefits available under the contract are not less than the minimum values and benefits required by or pursuant to the NAIC Standard Nonforfeiture Law for Life Insurance, model #808.

Any indebtedness on this contract will reduce the values shown.

[TABLE OF GUARANTEED VALUES
Male Non-Tobacco Age 35

END OF POLICY YEAR	CASH VALUE
1	$ 15,472.00
2	16,145.00
3	16,846.00
4	17,575.00
5	18,335.00
6	19,125.00
7	19,945.00
8	20,795.00
9	21,673.00
10	22,580.00
11	23,516.00
12	24,484.00
13	25,488.00
14	26,533.00
15	27,620.00
16	28,747.00
17	29,911.00
18	31,109.00
19	32,341.00
20	33,602.00

Age	
65	47,748.00
85	78,740.00
100	90,897.00
121	100,000.00**]**

SECTION 8 LOANS

8.1 Loan
You can get cash from us by taking a loan. If there is an existing loan, you can increase it. You may obtain a loan from us with this Contract as sole security if:

a. You give Written Notice; and
b. The total indebtedness after the loan will not exceed the net surrender value including the including the cash value of any dividend additions, and
c. The loan is at least $500.

We have the right to defer making a cash loan for up to six months from the date the loan is requested, except when the request is made to pay premiums on any contract with us.

8.2 Loan Interest
The loan interest rate charged will not exceed the greater of (1) and (2), where:

1. is the Interest Rate shown in the Contract Specifications plus 1% per annum; and
2. is the Moody's Corporate Bond Yield Average-Monthly Average Corporates for the calendar month ending two months before the beginning of the month in which your Contract Anniversary falls. If the maximum is at least one-half of one percent smaller than the rate we have set for the previous contract year, we will reduce the rate to a rate no more than that maximum. If the maximum is at least one-half one percent greater than the rate we have set for the previous contract year, we will increase the rate to a rate no more than that maximum. Moody's Corporate Bond Yield Average-Monthly Average Corporates referred to above is pushed by Moody's Investors Service, Inc. In the event it is no longer published, we will use a similar average established by applicable regulation.

Interest will accrue daily on loans. Accrued interest may be paid at any time at the equivalent effective rate. In the event you do not pay the loan interest charged in any contract year, it will be borrowed against the contract and added to the contract indebtedness and bear interest at the same rate.

When a loan is made, we will inform you of the rate and if any rate increase is to be made within 40 days. We will mail a notice to you and any assignee recorded at the Home Office at least 30 days before we make any rate increase which will apply to an existing loan.

8.3 Indebtedness
Indebtedness consists of all unpaid loans and accrued interest. Indebtedness may be repaid at any time. Any indebtedness will be deducted from the contract proceeds.

If indebtedness equals or exceeds the cash value, the contract will terminate. We will mail notice to you at least 31 days before termination. We will also mail notice to any assignee on our records. You can prevent termination by making sufficient repayment of the loan.

SECTION 9 BENEFICIARY

9.1 Designated Beneficiary
The beneficiary is the person or persons to whom the insurance proceeds are payable when the insured dies.
The beneficiary:

a. will receive the proceeds when the insured dies;
b. is named in the application for this contract; and
c. may be changed by the owner. The change is subject to the terms shown in the Change of Beneficiary provision.

If not otherwise provided:

a. The interest of any beneficiary who dies before the insured will pass to any other beneficiaries according to their interests.

b. If no beneficiary survives the insured, the proceeds will be paid in one sum to the owner, if living. If the owner is not living, the proceeds will be paid to the owner's estate.

9.2 Change of Beneficiary

The owner may change the beneficiary designation:

a. while the insured is alive; and

b. if the prior designation does not prohibit such a change; and

c. the consent of any irrevocable beneficiary is obtained.

A change will revoke any prior designation. No change is binding on us until it is recorded at our home office. Once recorded the change binds us as of the date you signed it. The change will not apply to any payment made by us before we recorded your request. We have the right to require that you send us this contract so we can record the change.

SECTION 10. PAYMENT OF INSURANCE PROCEEDS

10.1 Optional Payment Plans

At the time of their commencement, any benefits provided under this contract will not be less than those provided by the application of the Cash Surrender Value to purchase a single premium immediate annuity contract at purchase rates offered by us at the time to the same class of annuitants.

If no optional payment plan is selected, any benefits provided by this contract will be paid in cash.

The optional payout plans available to the Beneficiary upon death of the Insured are:

A. **Interest Deposit Account -** The allocated proceeds will earn interest annually at rates that we determine from time to time, but never less than one and one-half percent (1.5%) The interest may be paid periodically or left to accumulate. The payee may withdraw all or part of the account at any time.

B. **Payments For a Guaranteed Period** – We will periodically pay the amount that is calculated so that the allocated proceeds plus interest are fully paid over a guaranteed period that may be selected. The guaranteed period must be at least five (5) years. We reserve the right to set a maximum limit. The payee may not withdraw any of the account at any time.

C. **Payments Based on a Single Life**

1. **Life Only** – We will periodically pay the amount that is calculated so that the allocated proceeds plus interest would be fully paid over the payee's life expectancy. We will pay that amount as long as the payee is alive. We will make no further payments after the payee's death. The payee may not withdraw any of the account at any time.

2. **Life or Certain Period** – We will periodically pay the amount that is calculated so that the allocated proceeds plus interest would be fully paid over a period based on the payee's life expectancy and the probability that the payee would not survive a certain period that may be selected. The certain period must be either ten (10) or twenty (20) years. If the payee dies during the certain period, we will pay the present value of the remaining certain-period payments to the payout plan beneficiary pursuant to his or her election of a lump sum or an eligible payout plan. To be eligible, the payout plan must pay out at least as rapidly as the plan in effect when the payee died. If the payout plan beneficiary does not make such an election, we will pay the annuity proceeds in a lump sum. If the payee survives beyond the selected period, we will continue making the periodic payments until the payee's death. The payee may not withdraw any of the account at any time.

D. **Joint and Survivor Lifetime Annuity Payments** – We will periodically pay the amount that is calculated so that the allocated proceeds plus interest would be fully paid over a period based on the life expectancies of two (2) payees. We will pay that amount as long as one or both payees are living. Neither beneficiary may withdraw any of the account at any time.

E. **Other Plans** – Other periodic plans may be arranged with us.

10.2 Minimum Payment Guarantee

1. The amount of the periodic payment in Section 11.1 under paragraphs B through E will be determined by a single interest rate that we will declare when the plan takes effect and which will be at least one and one-half percent (1.5%). Payments that depend on one or more lives will also be determined by a mortality table that we will declare when the plan takes effect and which will be at least as favorable to the beneficiary as the Annuity 2000 Mortality tables, split by sex.

2. Tables 1, 2 and 3 in Section 11.5 show the minimum guaranteed payments for each plan in Section 10.1 under paragraphs B, C and D respectively under certain stated assumptions.

10.3 Who May Choose a Payment Plan

A choice of payment plan for insurance proceeds may be made by you while the insured is still alive. If no selection is made, the beneficiary shall have the right to select the plan. All choices of payment plans will take effect when recorded by us. When a payment plan starts, we will issue a contract which will describe the terms of the plan. We may require that you send us this certificate. If the payee is not a natural person, the choice of an income plan will be subject to our approval.

10.4 Frequency of Payments

Monthly, quarterly, semiannual or annual payments may be selected.

10.5 Payout Plan Guaranteed Payments

The monthly amounts shown are for each $1,000 applied. To change monthly payments to quarterly, semiannual or annual payments, multiply the monthly amount by 3.00; 6.02; or 12.08, respectively. The tables assume that no withdrawals are made, only the guaranteed interest of one and one-half percent (1.5%) is paid, and payments are made at the end of the payment mode selected. Tables 2 and 3 are based on the Annuity 2000 Mortality tables, split by sex.

TABLE 1 PAYOUT PLAN B: PAYMENTS FOR A GUARANTEED PERIOD

Years Selected	Monthly Amounts	Years Selected	Monthly Amounts	Years Selected	Monthly Amounts	Years Selected	Monthly Amounts
5	17.31	9	9.90	13	7.05	17	5.55
6	14.53	10	8.97	14	6.60	18	5.28
7	12.54	11	8.22	15	6.20	19	5.04
8	11.06	12	7.59	16	5.86	20	4.82

TABLE 2 PAYOUT PLANS C: PAYMENTS FOR LIFE

	No Certain Period				Certain Periods	
					10 Year	20 Year
Payee's Age	Male	Female	Male	Female	Male	Female
50	3.26	3.01	3.23	3.00	3.15	2.96
55	3.65	3.35	3.61	3.33	3.46	3.25
60	4.17	3.79	4.09	3.75	3.80	3.59
65	4.88	4.39	4.71	4.30	4.15	3.97
70	5.86	5.22	5.47	5.02	4.45	4.34

TABLE 3 PAYOUT PLAN D: JOINT AND SURVIVOR LIFETIME ANNUITY PAYMENTS

Male Age	Female Age				
	50	55	60	65	70
50	2.72	2.86	2.97	3.06	3.13
55	2.81	2.99	3.16	3.31	3.42
60	2.88	3.10	3.33	3.55	3.75
65	2.93	3.19	3.48	3.79	4.09
70	2.96	3.25	3.59	3.99	4.41

WHOLE LIFE INSURANCE
Insurance Payable at Death of Insured
Premiums Payable for Stated Period
Schedule of Benefits and Premiums in Section 1
Participating

[ ]
[ ]
[ ]
[ ]
[ ]

1100 West Wells Street
Milwaukee Wisconsin 53233
800-927-2547
[www.catholicknights.org]

SERFF Tracking Number:	*CAKN-126707906*	*State:*	*Arkansas*
Filing Company:	*Catholic Knights*	*State Tracking Number:*	*46131*
Company Tracking Number:	*19-710*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.111 Single Premium - Single Life*
Product Name:	*SPWL*		
Project Name/Number:	*CNO-19/19-710*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification
Comments:
Attachment:
Flesch Cert AR.pdf

Item Status: **Status Date:**

Satisfied - Item: Application
Comments:
Attachments:
2010 LF App.pdf
2010 LF App2.pdf

Item Status: **Status Date:**

Satisfied - Item: Illustration Certification
Comments:
Attachment:
2010 SPWL (Illustration_Cert).pdf

Item Status: **Status Date:**

Satisfied - Item: Regulation 19 Certification
Comments:
Attachment:
Reg 19 CERT AR signd.pdf

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: Catholic Knights

This is to certify that the forms referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
2010 SPWL	52.5

Daniel H. Strasburg, FSA, MAAA
Vice President and Chief Actuary
June 23, 2010

CATHOLIC KNIGHTS
Catholic values in action

Application for Membership and Insurance to:

[Catholic Knights]
1100 West Wells Street
Milwaukee, Wisconsin 53233
(800) 927-2547

☐ New Business
☐ Conversion from Certificate No: _____

☐ New Member
☐ Changes to Certificate No: _____

A. MEMBERSHIP

Proposed Primary Insured

☐ Male ☐ Female SS/ITIN No _____ DOB: _____ Age ____ State of Birth _____
Name: _____
First Middle Initial Last
Address: _____ _____ _____ _____
Street City State Zip
Home phone: _____ Work/cell phone: _____ Email: _____
Where can you be reached for additional information? _____
Best Days: M T W TH F Best times _____ ☐ a.m. ☐ p.m.
Are you a US Citizen, or do you have permanent residence status?
☐ Yes - Proof of Identity _____
☐ No - If not a U.S. citizen, provide 1-151 *(green card)* number _____ No. of years in US _____
Driver's License: _____ State _____
Previous Name/s: _____
Occupation: _____ Employer _____ Income _____
Is the Proposed Insured Catholic? ☐ Yes ☐ No Parish _____
If no, do you otherwise qualify for membership? Explain _____

Owner (*Must complete section if Owner is not the Insured)*

☐Individual Relationship to proposed insured _____
☐ Male ☐ Female SS/ITIN No: _____ DOB _____
Name: _____
First Middle Initial Last
Address: _____ _____ _____ _____
Street City State Zip
Home phone: _____ Work/cell phone: _____ Email: _____
☐ Trust Contact person _____ Tax ID No. _____
Phone _____ Email _____

Successor Owner

☐ Male ☐ Female SS/ITIN No _____ DOB: _____
Name: _____
First Middle Initial Last
Address: _____ _____ _____ _____
Street City State Zip
Home phone: _____ Work/cell phone: _____ Email: _____

Payor *(complete if Payor is other than insured or Owner)*

Relationship to owner and insured _____
SS/ITIN No: _____ DOB _____
Name: _____
First Middle Initial Last
Address: _____ _____ _____ _____
Street City State Zip
Home phone: _____ Work/cell phone: _____ Email: _____

POLICY DATE	POLICY NUMBER

Additional Proposed Insured

☐ Male ☐ Female SS/ITIN No _____ DOB: _____ Age ____ State of Birth _____

Name: _____

First Middle Initial Last

Address: _____ _____ _____ _____

Street City State Zip

Home phone: _____ Work/cell phone: _____ Email: _____

Where can you be reached for additional information? _____

Best Days: M T W TH F Best times _____ ☐ a.m. ☐ p.m.

Are you a US Citizen, or do you have permanent residence status?

☐ Yes - Proof of Identity _____

☐ No - If not a U.S. citizen, provide 1-151 *(green card)* number _____ No. of years in US _____

Driver's License: _____ State _____

Previous Name/s: _____

Occupation: _____ Employer _____ Income _____

Is the Proposed Insured Catholic? ☐ Yes ☐ No Parish _____

If no, do you otherwise qualify for membership? Explain _____

Children's Information *(List additional children in Remarks)*

☐ Male ☐ Female SS/ITIN No _____ DOB: _____ Age ____

Name: _____ HT _____ WT _____

First Middle Initial Last

☐ Male ☐ Female SS/ITIN No _____ DOB: _____ Age ____

Name: _____ HT _____ WT _____

First Middle Initial Last

☐ Male ☐ Female SS/ITIN No _____ DOB: _____ Age ____

Name: _____ HT _____ WT _____

First Middle Initial Last

Are there any children on whom coverage is not being requested? ☐ Yes ☐ No

If yes; child's name _____ Reason _____

Beneficiary*(List additional beneficiaries in Remarks)*

☐ **INDIVIDUAL** ☐ **ESTATE** ☐ **TRUST** ☐ **GIFT to PARISH or OTHER CHARITY**

Primary: Full Name Relationship Social Security/Tax ID No

_____

_____

_____

Contingent: Full Name Relationship Social Security/Tax ID No

_____

_____

_____

Parish/Charity Name _____ Amount or Percent _____

☐ Custodian for minors: Name _____ DOB _____ SS/ITIN/TAX No _____

☐ The share of any beneficiary who does not survive shall be paid in equal shares to the beneficiary's surviving children

B. COVERAGE

Plan Of Insurance; _____

Face Amount $_____ ☐ Single Premium _____

Amount remitted with this application in Exchange for the Society's receipt $_____

(See Receipt and Conditional Life Insurance Agreement)

Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly EFT _____ *(day)*

Dividend Option: ☐ Cash ☐ Paid Up Life Additions ☐ Interest ☐ Reduced Premium

Automatic Loan ☐ Yes ☐ No

(UL only) Option ☐ #1 Level ☐ #2 Increasing

UL planned premium $ _____

☐ Layer/Additions to UL Amount _____ =

POLICY DATE	POLICY NUMBER

Riders

☐ Accidental Death Benefit ☐ Waiver of Premium
☐Guaranteed Insurability Option ☐ Paid Up Addition
☐ Term Rider (Primary Insured) $_____
☐ Term Rider (Additional Insured) $_____
☐ Children's Term Rider $_____

Premium Class

Primary	☐ Tobacco	☐ Select Tobacco	☐ Non-Tobacco	☐ Select	☐ Select Plus
Additional Insured Primary	☐ Tobacco	☐ Select Tobacco	☐ Non-Tobacco	☐ Select	☐ Select Plus

We will issue the policy in the Premium Class for which the Proposed Insured qualifies

C. REPLACEMENT/SUITABILITY

1. Does any proposed insured have any existing coverage and/or pending applications for individual life insurance or annuities with this or any other company? (other than group) ☐ Yes ☐ No
2. Does any proposed insured intend to replace, discontinue or change any such coverage? ☐ Yes ☐ No

If YES to 1 or 2 provide the following information, and complete and return any required replacement forms

Insured Name	Policy No:	Amount	Company

D. PRELIMINARY DECLARATION OF INSURABILITY

Primary Height _____ Weight _____

1 Has the Proposed Insured ever been told s/he had or been treated for diabetes, cancer, heart disease, alcoholism, drug abuse, or high blood pressure? ☐ Yes ☐ No

2. Has the Proposed Insured ever had insurance or reinstatement denied, postponed, limited, or offered on a substandard basis? ☐ Yes ☐ No

3. Has the Proposed Insured used tobacco in any form in the past 12 months? ☐ Yes ☐ No

Additional Proposed Insured: Height _____ Weight _____

1 Has the Additional Insured ever been told s/he had or been treated for diabetes, cancer, heart disease, alcoholism, drug abuse, or high blood pressure? ☐ Yes ☐ No

2. Has the Additional Insured ever had insurance or reinstatement denied, postponed, limited, or offered on a substandard basis? ☐ Yes ☐ No

3. Has the Additional Insured used tobacco in any form in the past 12 months? ☐ Yes ☐ No

E. REMARKS

_____

_____

_____

_____

_____

F. AUTHORIZATION TO OBTAIN and DISCLOSE INFORMATION

I (we) have read all the questions and answers in the application. All responses are true and complete to the best of my (our) knowledge and belief. No coverage will be in effect until: a full application has been signed by the Proposed Insured; and a policy has been issued: and the full first premium has been received by the Society; and any amendments are signed. Any coverage will be subject to the terms and conditions of the policy.

I (we) have received the notification about the Federal Fair Credit Reporting act and the Medical Information Bureau.

I AUTHORIZE the following to release information about me to Catholic Knights or its reinsurers. Those authorized include a physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, a consumer reporting agency, and/or employers.

POLICY DATE	POLICY NUMBER

F. AUTHORIZATION TO OBTAIN and DISCLOSE INFORMATION (Continued)

I UNDERSTAND that this information may include diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment, and other non-medical information (such as credit reports and employer reports) concerning me. I authorize all sources, except MIB, to give records or knowledge to any agency employed by Catholic Knights. I authorize them to collect and transmit such information I UNDERSTAND they will use the information obtained through this Authorization to determine eligibility for insurance. Any information obtained will not be released to any person or entity EXCEPT to reinsuring companies, or other persons or organization performing business or legal services with my application. The Society may release this information when lawfully required, or as I further authorize.

I KNOW that I, or my authorized representative, may request a copy of this Authorization. I AGREE that a photographic or faxed copy of this Authorization shall be as valid as the original. I ACKNOWLEDGE that I received the "Notice to Applicant" form. I AGREE this Authorization shall be valid for two years from the date shown below.

G. AGREEMENT (check one)

☐ Catholic Knights conditional coverage receipt was given for this life insurance plan. I acknowledge that I have read the receipt provided and understand its terms, conditions and limitations. I understand that I will not receive any insurance coverage for my money unless a policy is issued as applied for.

☐ No conditional coverage receipt was given for this insurance plan. I acknowledge that I have not paid nay premium for this insurance. I understand that this insurance is not in effect and that the first premium must be paid upon delivery of the policy.

I hereby apply for insurance in the amount on the plan and at the rate stated in this application. I agree that the entire contract consists of this application for life insurance and all supplemental application forms required for the contract or change applied for the policy, the statement of insurability, and medical examination statements, the Articles of Incorporation and By-Laws of the Society.

IT IS AGREED:

1) I have read the application and all statements in this application are to the best of my knowledge and belief true, complete and correctly recorded.
2) No Representative of the Society has the authority to waive any question contained in the application or to modify the application in any way.
3) No Representative is authorized to change or waive any terms of this agreement or to make any promises or representations other than those contained in this agreement.
4) No information acquired by any agent shall bind the Society unless set out in writing in this application.
5) Unless otherwise provided in a conditional receipt bearing the date of the application, no liability exists until a contract is delivered, accepted by the owner and the first payment made. This must occur during the lifetime and insurability of the applicant under this contract and the health of all persons to be insured remains as stated in the application.
6) The contract applied for shall take effect on the later of the date requested by the applicant, or the approval date of the application from the Society at the Home Office.
7) When you accept the contract issued on this application, you are approving and ratifying any corrections, additions, or changes made by the Society. We do not make changes in the plan of insurance or payment without your written consent.
8) Except as provided in the Conditional Temporary Life Insurance Agreement Receipt, issued if the first premium for the contract applied for is paid, no insurance will take effect unless and until

a. A contract of insurance is issued and delivered
b. The first full premium is paid during the life time of the person to be covered; and
c. The health of all persons to be insured remains as stated in this application.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Dated at _____ on _____
City State Month Day Year

_____ _____
Signature of Proposed Insured Signature of Proposed Additional Insured

_____ _____
Signature of Parent/Guardian for Minor Signature of Owner (if other than insured)

_____
Signature of Agent Agent No. Split Advisor No._____ Percentage _____

POLICY DATE	POLICY NUMBER

CATHOLIC KNIGHTS
Catholic values in action

PART II SUPPLEMENTARY
Application for Membership and Insurance to:
[Catholic Knights]
1100 West Wells Street
Milwaukee, Wisconsin 53233
(800) 927-2547

Full Legal Name _____ Date of Birth _____

Social Security Number _____ Policy Number _____

Interviewer _____ Date of Interview _____

PROPOSED INSURED MUST COMPLETE ALL QUESTIONS. ALL "YES" ANSWERS MUST BE EXPLAINED AND REFERENCED IN REMARKS.

Has or does the person proposed for this insurance coverage:	Yes	No
1) Ever engaged in or expect to engage within the next two years any of the following:		
a. Aviation activities as a pilot or crew member?	☐	☐
b. Skin or Scuba Diving; organized motor vehicle or motor boat racing; mountain climbing; professional rodeo competition; skydiving; parachuting, hang-gliding?	☐	☐
2) Are you or do you intend to become a member of the Armed Forces (including Reserves or National Guard)?	☐	☐
3) a. Drink alcoholic beverages? If yes, how much per week? _____ (one drink = 12 oz. beer, 4 oz. wine, or 1 oz. hard liquor) Amount _____	☐	☐
b. Now or ever used heroin, cocaine, marijuana, or illegal, restricted or controlled substance, except as prescribed by a physician?	☐	☐
c. Ever had or been advised by a physician, practitioner, or court of law to have treatment for alcohol, drug, or substance abuse?	☐	☐
4) a. Had insurance or reinstatement refused, postponed, limited, offered, or quoted on a rated or substandard basis?	☐	☐
b. Will this insurance replace or change any existing life insurance or annuity contract?	☐	☐
c. Made within the past 5 years a claim for or received benefits compensation, or pension for any injury, sickness, disability, or impaired condition?	☐	☐
d. In the past 5 years been unable to work, attend school, or perform normal activities of like age and gender, or been confined at home.	☐	☐
5) Ever been cited for driving while intoxicated (DWI), or driving under the influence (DUI)?	☐	☐
a. Ever been cited for any other driving violation in the past 3 years?	☐	☐
6) Ever been convicted in a court of law for any reason?	☐	☐
7) a. Have you traveled outside the United States within the past 2 years or intend to travel outside the United States within the next 2 years?	☐	☐
b. Have you lived outside of the United States within the past 2 years or intend to live outside the Untied States within the next 2 years?	☐	☐
8) 8) Do you now use or have you ever used tobacco or nicotine in any form? If yes, indicate the type of tobacco used: ☐cigarettes ☐ pipe ☐ cigar ☐ chewing tobacco ☐ other If applicable, the date you stopped._____	☐	☐
9) a. Have a history in parents, brothers or sisters of mental illness, diabetes, heart, kidney or liver disease, high blood pressure, stroke or cancer? If yes, name persons(s), relationship(s), ages(s), conditions (s), and age when disease began in remarks section.	☐	☐
b. Give name, cause and age at death of father, mother, brother(s), sister(s) if deceased: _____ _____		
10) Full name and complete address of personal physician; the date, reason last seen and diagnosis: _____ _____		
11) Have you declared bankruptcy in the last 7 years or had any suits, judgments or liens against you? If yes, discharged date: _____	☐	☐

COMPLETION OF QUESTIONS 12-19 IS REQUIRED IN ALL CASES. ANY "YES" ANSWERS MUST BE FULLY EXPLAINED AND REFERENCED IN REMARKS.

AIDS TEST RESULTS OBTAINED AT AN ANONYMOUS COUNSELING AND TESTING SITE DESIGNATED BY THE STATE EPIDEMIOLOGIST OR AT A SIMILAR FACILITY IN ANOTHER JURISDICTION OR HOME TESTING ARE CONFIDENTIAL AND NEED NOT BE DISCLOSED. NONE OF THESE APPLICATION QUESTIONS SHOULD BE INTERPRETED AS ASKING ABOUT AIDS, UNLESS THE QUESTION SPECIFICALLY MENTIONS AIDS.

Has or does the person proposed for insurance coverage:	Yes	No
12) Ever been diagnosed or treated by a member of the medical profession for a disorder, disease or persistent discomfort of the following systems:		
a. Respiratory (lungs, bronchi, trachea, etc.) such as, but not limited to, TB, asthma, emphysema, bronchitis, shortness of breath?	☐	☐
b. Circulatory (heart, blood, arteries, veins, etc.) such as, but not limited to, high blood pressure, heart attack, chest pains, murmur?	☐	☐
c. Digestive (Throat, esophagus, stomach, intestine, liver, gall bladder, etc.) such as, but not limited to, ulcer, colitis, cirrhosis, hemorrhoids, bleeding?	☐	☐
d. Nervous (brain, nerves, etc.) such as, but not limited to, paralysis, stroke, fainting, dizziness, epilepsy, convulsions, recurring headaches?	☐	☐
e. Musculo-skeletal (muscles, bones, joints, spine, etc.) such as, but not limited to, neck/back problems, fracture, arthritis?	☐	☐
f. Genito-urinary (kidney, bladder, reproductive organs, etc.) such as, but not limited to, kidney stones, infection, bleeding, male or female disorders?	☐	☐
g. Glandular (thyroid, pancreas, adrenal, lymph glands, etc.) such as, but not limited to, abnormal growth or function, including diabetes?	☐	☐
13) Been diagnosed or treated by a member of the medical profession for:		
a. impaired sight, or eye disorder	☐	☐
b. impaired hearing, or ear disorder	☐	☐
c. hernia	☐	☐
d. skin disease	☐	☐
e. any sexually transmitted disorders or diseases	☐	☐
14) Been diagnosed or treated by a member of the medical profession for any mental, nervous, psychological, or emotional condition or disorder, such as, but not limited to, anxiety, depression, or nervous breakdown?	☐	☐
15) Now have or ever been diagnosed or treated for cancer, tumor, cyst, or growth?	☐	☐
16) Gained or lost more than 10 pounds in the past year? Amount: _____ Cause: _____	☐	☐
17) Within the past 5 years: (Refer to disclaimer concerning AIDS test results at top of page)		
a. Had any other impairment, sickness, injury, surgery not described above or any diagnostic test such as x-ray, EKG, lab tests?	☐	☐
b. Had a physical examination? If yes, list the reason for and results below.	☐	☐
c. Been advised to have or do the following which was not completed 1) any diagnostic test; 2) surgery; 3) hospitalization?	☐	☐
d. Been on, or now on, prescribed diet or medication? List description of medication or diet, date prescribed and name and address of prescriber in remarks	☐	☐
e. Currently take any herbs, vitamins, mineral supplements or other non-prescription remedies? List description of non-prescribed medications in remarks.	☐	☐
18) Been diagnosed or treated by a member of the medical profession the past 10 years for complications of pregnancy (such as C-section) or now pregnant?	☐	☐
19) a. Been treated or diagnosed by a member of the medical profession as having any disorder of the blood or immune system, including Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Or Human Immunodeficiency Virus (HIV)?	☐	☐
b. Ever been treated by a member of the medical profession as having the AIDS (TTLV-III) Virus or tested positive to FDA licensed blood tests?	☐	☐

Remarks:

For all yes answers list question number and give full details, including name; address, and telephone number of the medical professional or facility providing treatment; diagnosis, dates of diagnoses, consultations, tests and treatments:

I declare that all statements and answers in this application and any questionnaire or declaration of insurability completed in connection with this application are, to the best of my knowledge and belief, true, complete, and correctly recorded. A copy of this application will be attached to and made a part of the insurance issued upon it, and will be used to determine if coverage will be issued.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signature of Proposed Insured

Date

Signature of Owner/Applicant, if other than Proposed Insured

Signed at (City, State)

CERTIFICATE OF ILLUSTRATION

CARRIER: Catholic Knights

FORM DESCRIPTION	FORM NUMBER
Whole Life Policy	2010 SPWL

I, Daniel H. Strasburg, hereby certify that:

1. I am Vice President, Chief Actuary and Illustration Actuary of Catholic Knights and a member in good standing of the American Academy of Actuaries; I was appointed by the Board of Directors of said insurer to be the illustration actuary for *all* plans of insurance subject to the Life Insurance Illustration Regulation. The appointment was documented in the Board minutes dated March 2, 2010, a portion of which is attached to this certification. I meet the Academy requirements for making this certification and the requirements of applicable state regulations.

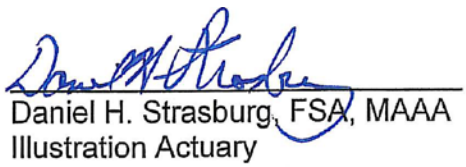
2. The form identified above will be illustrated;

3. The disciplined current scale to be used in the illustrations is in conformity with the Actuarial Standard of Practice for Compliance with the NAIC Model Regulations on Life Insurance Illustrations promulgated by the Actuarial Standards Board;

4. The illustrated scales to be used in insurer-authorized illustrations meet the requirements of the insurance illustration regulations;

5. This policy and non-guaranteed elements to be illustrated for it are consistent with:
    1. those illustrated for similar in-force policies and
    2. the non-guaranteed elements actually being paid, charged or credited to the same or similar forms.

6. The method used to allocate overhead expenses is from a generally recognized expense table based on fully allocated expenses representing a significant portion of insurance companies and approved by the National Association of Insurance Commissioners.



Daniel H. Strasburg, FSA, MAAA
Illustration Actuary
Vice President & Chief Actuary

7/2/2010
Date

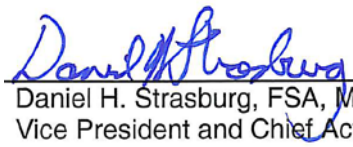
STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Company Name: Catholic Knights

Form Titles:	**Form Numbers:**
SINGLE PREMIUM WHOLE LIFE INSURANCE	2010 SPWL

I hereby certify that to the best of my knowledge and belief, the above forms and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.



Daniel H. Strasburg, FSA, MAAA
Vice President and Chief Actuary

July 7, 2010